MUNICIPAL EMPLOYEES BENEFITS PROGRAM
APPLICATION FOR DISABILITY BENEFITS
STATEMENT OF EMPLOYEE

Name of Applicant _____

Employer Name _____

Home Address _____

_____

Home Phone No. _____ Other Phone No. _____

Date of Birth _____ E-mail (optional): _____

Once completed, please forward this form and required attachments *(if applicable)* to:
The Municipal Employees Benefits Program PO Box 764, Winnipeg MB R3C 2L4

Please attach your answers on a separate page if the space provided is not adequate.

MEBP recommends submitting your claim and supporting documents as soon as possible. **Applications that are not fully completed or are missing attachments will result in a delay**.

For assistance, please call MEBP at (204) 926-7979 or toll free 1-800-432-1908

1. Nature of your medical condition
   a) Describe your psychological/ psychiatric or general medical condition which prevents you from performing your job at this time

      _____

      _____

   b) Please describe your symptoms in as much detail as possible _____

      _____

      _____

      _____

2. a) Date first seen by physician in relation to this medical condition _____

   b) How long have you been under the care of this physician? _____

   c) Date you anticipate you will be able to return to work _____

3. Date on which this medical condition caused you to cease work _____

4. Please list the dates you were away from work due to this medical condition. Attach a separate page if necessary. If you used vacation time for medical reasons, please include those dates.

   _____

   _____

   _____

5. **Declaration of Income**

a) Canada Pension Plan Disability (CPPD) Benefits

Have you applied for CPPD benefits? ☐Yes ☐No
If yes, was your application: ☐ Approved ☐Denied ☐Awaiting decision

If approved, attach a copy of your Notice of Entitlement.
If denied, attach a copy of your denial letter.
If awaiting a decision, please provide the date you applied: _____

b) Canada Pension Plan (CPP) Early Retirement Pension

If you are under the age of 60, please skip this question.
Have you applied for CPP Early Retirement Pension? ☐Yes ☐No
If yes, was your application: ☐ Approved ☐Denied ☐ Awaiting decision

If approved, attach a copy of your Notice of Entitlement.
If denied, attach a copy of your denial letter.
If awaiting a decision, please provide the date you applied: _____

c) Workers Compensation Benefits

Have you applied for Workers Compensation benefits? ☐Yes ☐No
If yes, was your application: ☐ Approved ☐Denied ☐Awaiting decision

If approved, attach a copy of your approval letter and a recent cheque stub.
If denied, attach a copy of your denial letter.
If denied, are you appealing the decision? ☐Yes ☐No
If awaiting a decision, provide the date you applied: _____

d) Employment Insurance (EI) Sick Benefits

Have you applied for EI Sick Benefits? ☐Yes ☐No
If yes, was your application: ☐Approved ☐Denied ☐ Awaiting decision

If approved, attach a copy of your Notice of Entitlement.
If denied, attach a copy of your denial letter.
If awaiting a decision, provide the date you applied: _____

e) Sick pay, Vacation pay, Wages

Are you receiving wages, sick pay or vacation pay from your employer?
☐ Yes ☐ No

f) Short Term Disability Benefits

Are you eligible to receive short term disability benefits (not sick pay) from either an employer or union sponsored plan? ☐Yes ☐No

g) Pension Income

Are you receiving other pension income from the MEBP Pension Plan?
☐Yes ☐No

h) Other Income

Are you are receiving benefits or income from any other source(s) not mentioned above, such as Manitoba Public Insurance (Autopac), other employment or other insurance providers? ☐ Yes ☐ No

If yes, please provide details and attach a copy of correspondence confirming payment details, along with a copy of a recent cheque stub or pay statement.

Declaration Form

I, _____, hereby make application to the Municipal Employees Benefits Program (MEBP) for a disability benefit and I authorize the administrators of the Disability Income Plan (the Plan/the Administrators) to obtain a medical report on my medical condition from the physician(s) below:

Family Doctor _____ Phone: _____

Address _____
Number/Street Town/City Postal Code

The following doctors have examined me within the last 6 months:

Name of Doctor	**Address**	**Appointment Dates**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach your answers on a separate page if the space provided is not adequate.

I understand that on a periodic basis I may be required to be examined by one or more physicians selected by the Administrator. The selected physician(s) will submit a report(s) to the Administrator regarding my medical condition. I authorize the Administrator or the Plan's Consulting Physician to provide any relevant information related to my medical condition to the selected physician for the purposes of such examination.

I consent, authorize and direct every physician, surgeon, or any other person who has examined me and every hospital or other institution to which I have applied for or in which I received treatment to disclose to the Administrator, or to the Plan's Consulting Physician any knowledge or information acquired pertaining to this claim. I authorize the Administrator to release to any person or institution acting on behalf of the Plan in regard to my claim for benefits, rehabilitation or employment, any knowledge or information on a discretional basis. I authorize the Administrator to release to any person or institution acting on behalf of the Plan to release to my employer information relevant to rehabilitation and return to the work place.

I understand that personal, and if applicable, health information is collected under the authority of *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act* and that a photocopy of this signed consent is sufficient to allow for the disclosure of information. I also understand that the personal information provided above is being collected for the purposes of determining my eligibility for coverage and administering the MEBP. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. I acknowledge and consent to the MEBP accessing personal information from my employer in the process of investigating and assessing any claims.

I further understand that the MEBP will limit access to personal information in my file to the MEBP staff or persons authorized by the MEBP who require it to perform their duties, to persons to whom I have granted access, and to persons authorized by law.

I acknowledge that I may exercise certain rights of access and rectification with respect to the personal information in my file by contacting the MEBP Administration Office by telephone at 1-800-432-1908 or (204)926-7979 or by mail at: Municipal Employees Benefits Program, PO Box 764, Winnipeg MB R3C 2L4.

Signature: _____ Date: _____

The Municipal Employees Benefits Program is committed to protecting the privacy, confidentiality, accuracy and security of the personal information it collects, uses, retains and discloses in the course of conducting business.

A photocopy of this authorization shall be as valid as the original

Member Responsibilities

I, _____, as an applicant for disability benefits from the Municipal Employees Benefits Program (MEBP) understand the following responsibilities;

1. In order to apply for disability benefits I must be under the regular care of a physician who is a registered medical specialist or health care practitioner in a field of medicine which is applicable to my condition. I must be undergoing a course of medical treatment or participating in a program of rehabilitation which is deemed appropriate by the Plan Administrator or the Plan Administrator's Consulting Physician.

2. If I am approved for disability benefits, I must remain under the care of a physician at all times and actively participate in any treatment plan(s) that may enable me return to work as deemed appropriate by the Plan Administrator.

3. I understand that the goal of a rehabilitation program is to enable me to return to the job that I left or an accommodated position with my pre-disability employer if I have medical restrictions. The availability of such occupations, jobs or work will not be a factor in the assessment of my claim.

4. If I am approved for disability benefits, I must notify MEBP immediately of any changes to my address or phone number. If I move beyond a reasonable commuting distance from my pre-disability employer without prior approval of the MEBP, I understand that my benefits may be discontinued.

5. If my application is approved, I understand that from time to time MEBP may ask me to complete a "Declaration of Earnings" form to declare earnings from other sources (i.e. CPP, EI, employment earnings, etc) and to provide supporting documentation (i.e. copies of pay statements). Failure to do so may result in a suspension or termination of disability benefits.

6. If I am approved for disability benefits, any accumulated sick leave remaining on my approval date, may be retained by my employer or paid to me. If paid to me, it will be deducted from my disability benefit.

7. I will repay the Disability Income Plan in full for any overpayment occurring as a result of my receiving income from the Canada Pension Plan, Workers Compensation, Employment Insurance, Manitoba Public Insurance, short term disability benefits and sick leave.

8. If medical opinions indicate that I am capable of work, I will be expected to resume employment.

Member Signature: _____ Date:_____

Witness Signature: _____ Date: _____

Print name of witness: _____